Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: Southwest Center Medical 7125 Marvin D Love #107 Dallas, TX 75237	MFDR Tracking #: M4-05-1228-01 DWC Claim #: Injured Employee:
Respondent Name: American Home Assurance Co. Box #: 19	Date of Injury: Employer Name: Wal Mart Stores Inc. Insurance Carrier #: C2292582

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Per Requestor's Table of Disputed Services, "No pre-authorization was needed. Patient started program 12/01/03, pre-auth was not required."

Principle Documentation:

1. DWC 60 package
2. CMS 1500s
3. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent states that as a result of their review, "no further payment was recommended towards the amount in dispute of $1,728.00."

Principle Documentation:

1. Response to DWC 60
2. EOBs
3. CMS 1500s

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and/or Description	Part V Reference	Amount Due
01/02/04 – 01/09/04	A, 240 / O,777,730	97545 WC CA	1, 2, 3	$432.00
01/02/04 – 01/09/04	A, 240 / O,777,730	97546 WC CA	1, 2, 4	$1,296.00
Total Due:				$1,728.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, Reimbursement Policies and Guidelines, and Division Rule 134.202 titled, Medical Fee Guideline effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by respondent with denial codes "A" (Pre-authorization not obtained), & "240" (Preauthorization not obtained), and with reconsideration denials "O" (Denial after reconsideration), "730" (Reduction or denial of payment resulting after reconsideration was completed), and "777" (Based on the diagnosis, treatment patterns and/or number of visits, the treatment exceeds our physician parameters. Refer to Dr. Report).

2 Rule 134.600 (h) (9), amended to be effective 03/14/04, states that all facilities CARF and Non-CARF must have services pre-authorized, however, per Advisory 2003-22, "Each work hardening/work conditioning program that has been initiated prior to January 1, 2004, will not require preauthorization for the remaining duration of that program". In this case, the

patient began the program on 12/01/03, consequently preauthorization was not required.

3. CPT code 97545-WC- CA was billed for dates of service 01/02/04 – 01/09/04: Per Rule 134.202 (e) (5) (i) The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. Per Rule134.202 (e) (5) (B) (i), the first two hours of each session shall be billed and reimbursed as one unit. Per Rule134.202 (e) (5) (B) (ii), reimbursement shall be $36.00 per hour. Therefore, reimbursement is recommended in the amount of **$432.00 ($36.0 X 100% = $36.00 x 12 (6 Units).**

4. CPT code 97546-WC- CA was billed for dates of service 01/02/04 – 01/09/04: Per Rule 134.202 (e) (5) (i) The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. Per Rule134.202 (e) (5) (B) (ii), reimbursement shall be $36.00 per hour. Therefore, reimbursement is recommended in the amount of **$1,296.00 ($36.00 X 100% = $36.00 X 36 (Units).**

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202, Advisory 2003-22, 134.600

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$1,728.00** plus accrued interest, due within 30 days of receipt of this Order.

Decision and Order:

	Eileen V. Atkinson	May 1, 2007
Authorized Signature	Medical Fee Dispute Resolution Officer	**Date**

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.